

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Phone (Home): _____
(Work): _____ Ext.: _____ Cell #: _____ **E-Mail** _____

Home Address _____
Street Apartment # _____
City State Zip Code _____

Whom may we thank for referring you to our practice? _____ -

Address _____

This office requires 24 hour notice for cancellations, otherwise you will be billed.

Health Information - Please check all that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Women - Postmenopausal |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy due _____ | <input type="checkbox"/> Medications: _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Growths/Tumors | <input type="checkbox"/> Radiation Treatment | _____ |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Headaches/Neckache | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Conditions | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tinnitus | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease | _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Vertigo | _____ |

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
- Do you have any health problems that need further clarification? Yes No
- If yes, please explain: _____
- Are you now under the care of a physician? Yes No
- If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Address: _____

Dental Information - Date of Last Dental Visit: _____

- Have you ever had any complications following dental treatment? Yes No
- If yes, please explain: _____
- Do you feel that you would like to improve the appearance of your teeth and smile? Yes No
- Have you been previously treated for unexplained facial pain or a jaw joint problem? Yes No
- Do you have difficulty, pain, or both when opening your mouth (i.e. chewing or yawning)? Yes No
- Do your jaws regularly feel stiff, tight, or tired? Yes No
- Does your jaw "get stuck," "lock," or "go out"? Yes No
- Are you aware of noises in the jaw joints or any recent changes in your bite? Yes No
- Have you had a recent injury to your head, neck, or jaw? Yes No
- Are the pressures of work significantly stressful? Yes No
- Do you feel fatigued on awakening in the morning? Yes No
- Are you aware of grinding or clenching of your teeth? Yes No
- Do you have problems sleeping or with snoring? Yes No
- Do you have frequent bad breath or an unpleasant taste in your mouth? Yes No
- Do you feel you could improve your dental home care regimen? Yes No

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____

Date _____

